# CAMP STAR APPLICATION – SUMMER OF 2015

**CHILD'S NAME**_____ D.O.B._____AGE_____SEX_____

ADDRESS_____ZIP_____PHONE_____

PICK UP AND DROP OFF ADDRESS (IF DIFFERENT) _____

DOES YOUR CHILD REQUIRE TRANSPORTATION? YES / NO

HOUSEHOLD MALE'S NAME_____PHONE_____

HOUSEHOLD FEMALE'S NAME_____PHONE_____

SOCIAL WORKER_____PHONE_____

DOCTOR_____PHONE_____

HEALTH INSURANCE CO. _____POLICY # _____

Does your child speak English? _____ Yes/No IS THERE ANY OTHER LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME? YES / NO-- OTHER LANGUAGE: _____

**IN CASE OF AN EMERGENCY PLEASE CONTACT:**

NAME_____RELATIONSHIP_____PHONE_____

NAME_____RELATIONSHIP_____PHONE_____

**IS MEDICATION GIVEN REGULARLY? YES / NO**
**IF YES, YOUR PHYSICIAN WILL HAVE TO FILL OUT A FORM SEE PAGE 6 (MEDICATION FORM).**
**DOES YOUR CHILD HAVE ANY ALLERGIES? YES / NO-if yes, what?** _____
**IS YOUR CHILD TOILET TRAINED? YES / NO**
**DOES YOUR CHILD HAVE ANY MEDICAL RESTRICTIONS/LIMITATIONS? YES / NO** *-if yes, what?*

_____

**WHEELCHAIR /** _____**HEARING AIDE /** _____ **COMMUNICATION BOARD**_____
**SIGN LANGUAGE /** _____**BRACES OR CRUTCHES /** _____ **ASTHMA INHALER**_____
**Any other comments for us about your child:**

_____

**CHILDS SCHOOL**_____ **GRADE LEVEL**_____
**IS YOUR CHILD IN REGULAR EDUCATION CLASSES? YES / NO**
**DOES YOUR CHILD ATTEND SPECIAL NEEDS CLASSES (CHAPTER 766)? YES / NO**
**DOES YOUR CHILD HAVE A ONE TO ONE AIDE IN SCHOOL? YES / NO**
**DOES YOUR CHILD GET PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY IN SCHOOL? YES / NO**
**IF YES EXPLAIN:** _____
**DOES YOUR CHILD HAVE ANY SPECIFIC BEHAVIOR PROBLEMS**
**(i.e. verbal or physically aggressive behavior, ability to stay with the group, other)? YES / NO**
**IF YES EXPLAIN:** _____

_____

## Please check off which session(s) interested in:

| SESSION ONE<br>Wed, JULY 1st-Tues, JULY 21st | SESSION TWO<br>Wed, JULY 22nd- Tues, AUGUST 11th | SESSION ONE & TWO<br>Wed, JULY 1st- Tuesday, AUGUST 11th |
|---|---|---|
| | | |

HAS YOUR CHILD EVER ATTENDED CAMP STAR? _____ Summer of _____

***IMPORTANT*: SEND IN THE APPLICATION, PHYSICAL/IMMUNIZATION FORMS, & PAYMENT RIGHT AWAY!**

Camp Star receives money from Community Development each year and we are **required** to provide a self declaration of the following:
**(Please check the appropriate response TO EACH SECTION BELOW or your child will not be admitted)!**
**For example if you have 2 people (mother and son) and your income is $22,000, you would go to the 2 persons row and make a check mark in the 21,001-$35,000 spot.**

**Number of Family Members (parents and children) #_____**

| **III. Income of participant household (Updated as of December 2013)** | | | | |
|---|---|---|---|---|
| | Below | Between | Between | Above |
| 2 persons | $21,000_____ | $21,001-35,000_____ | $35,001-52,650_____ | $52,651_____ |
| 3 persons | $23,650_____ | $23,651-39,400_____ | $39,401-59,250_____ | $59,251_____ |
| 4 persons | $26,250_____ | $26,251-43,750_____ | $43,751-65,800_____ | $65,801_____ |
| 5 persons | $28,410_____ | $28,411-47,250_____ | $47,251-71,100_____ | $71,101_____ |
| 6 persons | $32,570_____ | $32,571-50,750_____ | $50,751-76,350_____ | $76,351_____ |
| 7 persons | $36,730_____ | $36,731-54,250_____ | $54,251-81,600_____ | $81,601_____ |
| 8 persons | $40,890_____ | $40,891-57,750_____ | $57,751-86,900_____ | $86,901_____ |

**Ethnicity (SELECT ONLY ONE):** Hispanic or Latino _____ **or Not** Hispanic or Latino _____

| **Racial Profile** | | **Check off 1 Race Below:** | | | | Other Multi-Racial | |
|---|---|---|---|---|---|---|---|
| White | | Asian | | Native Haw./Other Pacific Islander | | Amer. Indian/Alaskan Native & White | |
| Black/Afr. Amer. | | Asian & White | | Amer. Indian/Alaska. Native | | Hispanic Black | |
| Black/African Amer. & White | | Asian/Pacific Islander | | Amer.Indian/Alaskan Native & Black/African Amer. | | Hispanic White | |

| **FAMILY STATUS:** | Female Head of Household _____ | Male Head of Household _____ | 2 Parent Household _____ |
|---|---|---|---|

## CHILD RELEASE PERMISSION

## *IMOPORTANT INFORMATION! WE WILL NOT RELEASE YOUR CHILD TO ANYONE NOT INDICATED BELOW*

PERSON(S) OTHER THAN PARENT(S) AUTHORIZED TO TAKE A CHILD FROM CAMP (IF ANY). PLEASE LIST ALL. (IDENTIFICATION REQUIRED AT TIME OF PICKUP).

Name: _____ Relationship:_____ Address:_____ Phone:_____
Name:_____ Relationship:_____ Address:_____ Phone:_____
Name:_____ Relationship:_____ Address:_____ Phone:_____

**HOSPITAL RELEASE FORM**

Childs Name: _____Person to contact in parent's absence:_____
Address:_____ Telephone_____

*In the event my child needs emergency medical care while in program at Camp Star, I hereby give permission for the hospital to give such emergency treatments as are considered necessary or desirable by medical judgment, including administration of anesthesia. I agree to assume all medical expenses incurred by my child while under the supervision of Camp Star.

Signature_____ Date_____

**VARIOUS RELEASES**

*I hereby give permission to Camp Angelina-Star to photograph my child; I understand that the photographs may be used for news media.
*I hereby give my permission for my child to go on field trips while attending either Camp Angelina or Star.
*I hereby give my permission for my child to use swimming facilities and participate in swim program during Camp
*I hereby give my permission for the Springfield Parks Department to release my name, address and phone to the *Angelina/Star Parents Group. This group is concerned with the well-being of the program and may need your help at a future date.
Parent/Guardian Signature: _____

Dear Parents or Guardians:

Camp STAR/ Angelina is a day camp that serves special and non-special needs children. The program consists of swimming, arts and crafts, sports, music, games, nature and field trips. The cost for Springfield residents is $275 per three-week session/$475 per 6 week session and is all inclusive of field trips, lunch, snack, staffing and bus transportation to and from home. The camp has been in operation for the past thirty-five years and we pride ourselves on the quality of the staff, which in turn affects the quality of our program.
The summer program is as follows:

**CAMP STAR/ANGELINA - 886-5219**

**WHO**: Children and youth 4 - 22 years of age (must be toilet trained) with some developmental delay or learning disability, some degree of physical disability, and/or ADHD (Attention Deficit Hyperactivity Disorder). Also open to non-special needs children. Our staff ratio is one counselor to four children so campers must be independent in eating/toileting and must be able to stay with their group due to safety concerns, particularly traffic. If your child has 1:1 requirements or issues with being unable to stay with a group, our camp cannot meet your child's needs in this setting. We suggest you contact your child's teacher for a summer program that will better meet your child's needs.
We reserve the right to discuss suspension and/or expulsion if safety for the camper, peers and/or staff is affected.

**WHERE**: Forest Park Camp STAR

**WHEN**: Open for two three-week sessions in July and August, Monday - Friday from 9:30 A.M. - 3:00 P.M. (Dates are tentative) Session I: July 1st- July 21st
Session II: July 22nd- August 11th

**FEE**: Fee explanation below.

**WHAT**: A recreation day camp. *Transportation is provided by the Park Department for Springfield children.

**Springfield Fee: The fee for summer camp is $275.00 for a 3-week session or $475.00 for 6 weeks. If you have a more than one camper, the rates go as follows: The fee for your second or more children is $200.00 per 3-week session or $400.00 for 6 weeks.** THERE IS A MINIMUM DEPOSIT OF $150.00 IF YOU CHILD IS DOING ONE SESSION AND $200.00 IF YOUR CHILD IS DOING BOTH SESSIONS****Please make the check out to Parents and Friends of Star Inc.***
**Out of Town Rate: Have your special needs education office contact us for prices. Out of town campers must provide their own transportation.**
**There is a limited amount of scholarship money available. You must submit a copy of your W2 form, a copy of your tax return, and a letter indicating why you need assistance or any extenuating circumstances. Include income and verification receipts such as payroll check or other source of income in order to help us determine your eligibility.**

**SPRINGFIELD PARK & RECREATION DEPARTMENT**
**CAMP STAR AND ANGELINA SUMMER DAY CAMPS**

Please read the following instructions carefully:

1. **We will take applications at any time but we advise parents to get applications and release forms with $275 deposits made out to Parents and Friends of Star Inc.** ***as soon as possible.*** Camp applications are accepted on a first come-first served basis.

2. The bus company will not pick up any child for camp until **ALL forms and payment** are received in this office.

3. For parents/guardians who pick up children on a daily basis, **YOU MUST BE ON TIME.** For every **late pick up,** parents/guardians will be **charged an extra $15.00**. The same policy applies to bus riders-If you are not home to meet your child's bus, you will be charged the late fee.

4. **We highly recommend that you send in your application and deposit now.** We do fill up and it is to your advantage to get your application and payment in as soon as possible. **The physical form is due on June 15th. Keep a copy of your physical! Physical examinations from July 2013 to the present are considered acceptable. Contact your physician for a copy. Immunizations MUST be current. SCHEDULE YOUR CHILD'S PHYSICAL NOW, AS MOST PHYSICIANS ARE ALREADY BOOKING MONTHS IN ADVANCE. NO CHILD WILL BE ADMITTED TO CAMP WITHOUT A PHYSICAL AND IMMUNIZATIONS!!!**

5. MEDICATION - If your child must take any **medications during the hours of the program**, you must contact me, (Tony Restivo) at my office right away (886-5219). We will send you a form **to be completed by your doctor**. This is not necessary if medication is taken at other than camp hours.

**ADMITTANCE POLICY**

1. Priority will be given to Springfield residents.

2. Persons admitted to past camp programs will be given preference over new applicants who have never enrolled in our programs.

3. If you enroll your child both sessions, please list preference as to which session most desired. The purpose of this is to make sure that applicants will be enrolled in at least one session so that we will minimize the number of people turned down due to over enrollment. (See application forms). If you elect to go to two sessions, send one check for $250 and second separate $50 check for a deposit for the second session. **Please write your child's name on the MEMO line of the check!** If you do not get into your second session, your deposit check will be returned. If you're interested in both sessions, get your checks in immediately.

4. You will be notified by June 20th or earlier as to your acceptance into our camps.

5. This listed closing date is important. Please submit the application prior to that date to be assured of entry into the program. Applications are registered according to the above-mentioned guidelines and on payment received and first come, first served basis. **SEND APPLICATION IN AS SOON AS POSSIBLE; PHYSICAL FORMS MUST BE RETURNED BY JUNE 15th. Make checks out to Parents and Friends of Star, Inc.**

6. **Please send to:Springfield Park Department- c/o Therapeutic Recreation**
**200 Trafton Rd/ Forest Park**
**Springfield, MA 01108**

For those who prefer to fax in their application, medication and physical forms, the fax number is 787-6624-address it to Camp Star

# MASSACHUSETTS SCHOOL HEALTH RECORD
## Health Care Provider's Examination

**Name** _____ ☐ Male ☐ Female Date of Birth: _____
**Medical History** _____

**Pertinent Family History**

**Current Health Issues**

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

**Current Medications (if relevant to the student's health and safety)** *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

**Physical Examination** **Date of Examination:** _____

Hgt: _____(____%) Wgt: _____(____%) BMI: _____(____%) BP: _____

*(Check = Normal / If abnormal, please describe.)*

☐ General _____ ☐ Lungs _____ ☐ Extremities _____
☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____
☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____
☐ Dental/Oral _____ ☐ Genitalia _____

**Screening:**

| | (Pass) | (Fail) |
|---|---|---|
| Vision: Right Eye | ☐ | ☐ |
| Left Eye | ☐ | ☐ |
| Stereopsis | ☐ | ☐ |
| Hearing: Right Ear | ☐ | ☐ |
| Left Ear | ☐ | ☐ |
| Postural Screening: (Scoliosis/Kyphosis/Lordosis) | ☐ | ☐ |

**Laboratory Results:** ☐ Lead _____ Date _____ ☐ Other _____

**The entire examination was normal:** ☐

**Targeted TB Skin Testing:** ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:

☐Y ☐N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____ _____
Group Practice Telephone

_____ _____ _____ _____
Address City State Zip Code

*Please attach additional information as needed for the health and safety of the student.* *MDPH 12/14/04*

## Camp Star- Springfield Parks & Recreation
**Prescription/Medication Form**

Standard Medication Order Form
For **ALL** Medications to be administered during Camp Hours

***Prescription Form to be completed by Physician/Nurse Practitioner***

**Camper's Name:** _____ _____ **D.O.B:**_____
**Gender**: M / F **Last** **First**

**Start Date** Order is in effect: _____ **Ending Date:** _____
(All medication orders need to be renewed each program year on a separate order form)

**Name of Medication:** _____

**Medical Diagnosis for use of this Medication:** _____ **Allergies:** _____

**Administration:** Route: _____ Dosage: _____ Time: _____ or PRN
**PRN Medication guidelines:** Frequency _____ (please circle) May repeat: x1 or 2
**Specific indication/directions for PRN Medications:**

_____

_____

**Side Effects:** _____

If this RX is for an inhaler or Epi-Pen, can this student self-administer? (Please circle) YES/NO

(PRINT) _____ (SIGN) _____ _____
**Physician/Nurse Practitioner Name** **Signature** **Date Ordered**

**PLEASE PROVIDE PHYSICIAN'S OFFICE STAMP IN SPACE PROVIDED:**

***To be filled out by Parent/Legal Guardian***

- I request that my child be assisted in taking the above medication as prescribed by the PCP/NP during camp hours by an authorized person or is permitted to self-medicate themselves as prescribed by the physician and authorized by me.
- I give my permission for the camp nurse to discuss with the prescriber and camp staff as necessary information on this form.

_____ _____
**Parent/Guardian Signature** **Date**

**Home Phone:** _____ **Cell Phone:** _____
**Emergency Phone:** _____

_____ _____
***Camp Nurse Signature*** **Date Received**

_____ _____
***Nurse Signature that verified orders with computer orders*** **Date Verified**

**A separate form must be completed for each medication that must be administered by camp staff. If additional forms are needed, please call: (413) 886-5219. Thank You!! Camp Administration**

# ***Medication and Field Trips***

Dear Parents/ Guardians:

We will be having numerous field trips this summer where nursing coverage will ***not*** be available. Could you please fill out the form below and send it back to camp.

Child's Name_____

Medication_____Dossage_____Time of Administration_____
Medication_____Dossage_____Time of Administration_____
Medication_____Dossage_____Time of Administration_____

**We leave for group trips at 10:30 and return to camp at 2:30. Our nursing coverage stays at the Camp. Please check-off one of the following options for field trip medication.**

Medication can be administered by the nurse for group trips at 10:30 AM _____.
Medication can be administered by the nurse for group trips at 2:30 PM_____.
Medication cannot be changed, it must be administered at _____ AM / PM

**********

**AUTHORIZATION OF PARENT OR GAURDIAN CONCERNING THE ADMINISTRATION OF MEDICATION BY CAMP PERSONNEL ON FIELD TRIPS**

To CAMP STAR / CAMP ANGELINA Date _____

I hereby request the medication ordered by the physician for my child be administered by Camp nursing personnel and / or be self administered under supervision on field trips by Camp counselors.

_____
Signature of Parent / Guardian

_____
Home Phone

_____
Work Phone

_____
Emergency Phone

If permission is not given for camp personnel to administer medication on field trips, your child will not be allowed to go with his/her group on these trips.

***See Back***

**Pool Registration for the pool at Forest Park**
**We sometimes take the campers over to Forest Park Pool as an added swim time each day. This form must be completed in order to allow this.**

Please fill out this form for each camper separately.
Parent Name_____ Parent Date of Birth__/__/__
Childs First Name _____ Middle Initial __ Last Name _____
Gender: Male_____ Female _____
Street Address _____
City/Town_____
Zip code _____
Date of Birth: Month _____ Day _____ Year_____
Home Phone (413) _____-_____

EMERGENCY CONTACT (other than parent/guardian)

Name _____ Relationship_____

Day Phone (  ) _____-_____